9/22/10 #1

AARP Illinois
Chicago Office
222 N. LaSalle Street
Suite 710
Chicago, IL 60601

T 1-866-448-3613
F 312-372-2204
TTY 1-877-434-7598
www.aarp.org/il

AARP Illinois Testimony
To the Illinois Health Reform Implementation Council
Wednesday, September 22, 2010

Thank you very much for this opportunity to provide AARP's perspective on the implementation of the Affordable Care Act. We believe with the Council hosting this hearing (and others like it) is not only timely but also an important endeavor that will likely provide important groundwork necessary to implement the Affordable Care Act in Illinois especially a state insurance exchange. I am looking forward to participating in this session, but wanted to also give you our thoughts on this subject in writing.

As you probably know, AARP is a nonprofit, nonpartisan organization with a membership that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. From AARP's inception over 52 years ago, our founder Dr Ethel Percy Andrus, created AARP on the mission of making life better for older Americans. We've been fighting for many issues over the years including health care reform. After careful analysis, AARP fought for the Affordable Care Act because the reforms will benefit our members and all older Americans. We do understand a lot of people are confused about the new law. It's complicated. And a lot of things have been said, including a lot of inaccurate things. In all the political squabbling, Americans have heard too little about what the reforms will mean for them and their families.

We believe this law brings us so much closer to helping millions of older Americans get quality, affordable health care. For too long, our members and others have faced spiraling prescription drug costs, discriminatory practices by insurance companies and a Medicare system awash in fraud, waste and abuse.

The law protects and strengthens guaranteed benefits in Medicare, including closing the dreaded Medicare Part D 'doughnut hole,' a gap in prescription drug coverage that is life threatening for many. Annual checkups and screening tests that can detect problems at an earlier and treatable stage will be covered with no copayments or deductibles. Medicare also will give bonus payments to doctors for primary care, which is a way to keep doctors' doors open for seniors.

Also, the law cracks down on abusive insurance company practices by strictly limiting their ability to charge higher premiums based solely on age. If someone has a medical condition, or develops one, insurance companies will no longer be able to deny

Springfield Office
T 1-866-448-3617
F 217-522-7803
TTY 1-877-434-7598

affordable coverage, drop someone or price him or her out of coverage.

In planning for future long-term care needs, individuals will be able to enroll in a voluntary national insurance program that will provide cash benefits if they have a qualifying disability that limits day-to-day living. Independent living is another priority of the new law. States will get added financial support for home and community-based services so important to seniors who want to remain independent and in their own homes as they age. But in order to take full advantage of that support the state will need protect home and community based services already being provided and move toward a more balanced and less institutionally heavy long term care system.

This law benefits more than those over the age of 65. The new law affects everyone including those 50-64 years of age. According to AARP research, 11.8 percent of Illinoisans in this age group were uninsured as of 2007. According to the Kaiser Family Foundation, of the 1.4 million uninsured Illinois adults (ages 19-64) only 4.5% have incomes higher than 400% of the Federal Poverty Law (FPL). So, almost all of the currently uninsured will be eligible for federal tax subsidies to pay for the state health exchange coverage starting in 2014.

We understand that the Council is looking for specific feedback and recommendations to implement a state health exchange. While the basic function of Exchanges is to provide access to health insurance and subsidies, they can and should be leaders in transforming the delivery of health care in Illinois. Their potential control of a new and commanding share of the insurance market will allow them to elevate insurance and health care standards throughout the nation. Accordingly, our Exchanges should use plan selection standards and selection process that promote affordability, robust competition, consumer satisfaction, health care network quality and adequacy, easy comparison of plans, reduction of disparities, care management, preventive services, adoption of health information technology (HIT), prompt access to care, and cost containment. When fully implemented, the Exchanges should offer the premier models for insurance that significantly improves the health status of enrollees and the delivery of coordinated, high quality health care while containing the costs of insurance and medical care.

Exchange governance
Consumers should be well represented in the design and operation of the Exchanges including those between 50 and 64. This group is more likely to have pre-existing conditions that make insurance difficult or impossible to obtain due to underwriting decisions or high cost resulting from age-based premiums. The governing body's deliberations and decisions should be transparent, and should provide opportunity for public input.

Exchange needs adequate authority to fulfill its responsibilities. Exchanges need the legal authority to make the best plans and services available at affordable prices. The Exchange should have authority to use negotiations and competitive bidding in the plan selection process in order to maximize the value of coverage offered and simplifies choices for buyers. Without the ability to negotiate for the best offerings for consumers

or to limit offerings if needed to assure an adequate risk pool, the opportunity for an Exchange to obtain improvements in benefits, quality and cost for those in the individual and small group markets may be foreclosed.

The Exchange should set high and realistic minimum standards for the selection of plans to be offered. This should include uniform minimum product standards for costs, benefit design, call centers, quality, and network adequacy. Such uniformity will facilitate negotiations and consumer selection among plans offered through the exchange. The number of plan providers should be limited to facilitate consumer comparison and meaningful choice in plan selection and to foster competition. Exchanges must offer more than a menu with too many options and too few tools for meaningful comparison. Standardization of benefit packages would greatly enhance comparison-shopping by consumers and employers and would facilitate price negotiation or competitive bidding processes. While costs and coverage are critical elements, competition for inclusion in the Exchange should also factor in quality-related standards, including the adequacy, accessibility, and outcome-based quality of each plan's provider network; consumer satisfaction; and systems to reduce disparities in access and health care outcomes based on race or ethnicity.

Information, education and outreach, marketing are critical.
To make the market more accessible to individuals buying coverage in the Exchange, key initiatives must build ongoing education and outreach on a base of good, understandable consumer information about coverage options, plan benefits and costs. Based on experience in states that have undertaken reform efforts, devoting resources to marketing the Exchange and its products and outreach initiatives need to be a part of the planning, not an afterthought. These resources and efforts make a difference. Navigator programs are a part of this, and will be important for reaching out to diverse groups that may be harder to reach due to language and cultural differences or lack of familiarity with health
insurance. AARP will play what part we can in efforts to educate our members, as we did when the Medicare drug benefit began.

Creating seamless eligibility and enrollment for consumers. Since the Exchange is charged with determining if applicants are eligible for Medicaid, CHIP, other public coverage programs as well as new premium and cost-sharing subsidies for private coverage, it will need to develop a system capable of performing this task. This will require collaboration among state agencies operating public coverage programs as well as with HHS and Treasury. We don't underestimate the challenge that this presents, but hope that it may lead to some creative thinking that can simplify some existing eligibility and enrollment procedures and practices. This is particularly important in an economic climate where many of those who will rely on Exchanges, Medicaid and other programs experience frequent changes in income and other circumstances. We encourage the development of a single application for all state and federally subsidized health programs and seamless processing of applications through the Exchange. The goal should be consistency and stability in coverage and health care services as individuals' circumstances change and they move between Exchange, Medicaid, CHIP and other state-administered health care programs. We will need systems to prevent gaps in

coverage and disruptions in medical care and to ensure that consumers are not forced to deal with multiple agencies and onerous application and documentation requirements. We emphasize this point because many individuals and families with incomes <400% of the federal poverty level (approximately $88,000 for a family of four) have incomes and family situations that vary significantly over a year.
Medicaid regulations and policy may also need to be modified to ensure the integration of the Medicaid program with the Exchanges. From a consumer's perspective, Exchanges should not be designed in isolation from efforts to streamline Medicaid, as this harmonization is key to the consumer's experience in accessing affordable and continuous health coverage.

Disclosure, transparency, and oversight are key roles. Individuals and small groups shopping for coverage on their own are often at a disadvantage in terms of evaluating their plan options and the companies offering those options. The Exchanges do some of the hard work for consumers, by shifting through plan packages, facilitating comparisons based on cost, value, health care quality and consumer service - much as large employers do for their employees. By approaching the job of putting together the packages that offer meaningful choices, and providing consumers information that helps them differentiate how the product choices in terms of benefits, networks, quality, cost as well as company history on rate increases, claims practices, etc. Exchanges can ease the process of buying coverage for the consumer. Similarly, the Exchanges must be advocates for enrollees who experience difficulty in obtaining timely access to quality health care.

Creation and development of Exchanges can't be done in isolation from the insurance market. As we've learned in the past decade, for purchasing pools to be sustainable they need to be operating on a level playing field with the market outside the pools. Otherwise adverse selection undermines them. This means that in considering the creation and development of reforms, it is essential that the regulations require a uniform regulatory framework governing the Exchanges and the broader markets
HHS must make a decision to allow a state to establish and operate its own Exchange by the end of 2012. One factor will be conformity to federal insurance market standards. By that deadline, states would need to have enacted legislation, effective before 2014, codifying at the state level the insurance market reforms made by the Act. These include prohibiting rescissions, annual and lifetime coverage caps; requiring insurers to provide dependent coverage to age 26, and appeals procedures and remedies; establishing review procedures for proposed premium increases; establishing minimum loss ratios; requiring guaranteed issue and renewal of coverage; prohibiting denials of coverage or exclusions based on preexisting conditions; establishing limitations on waiting periods; requirements for comprehensive coverage, clinical trial participation, and coverage of preventive services without cost sharing; and limiting age banding to three to one or less and tobacco use banding to one and a half to one. Illinois may also need state legislation establishing a coordinated system between the Exchange, the state Medicaid agency and other agencies administering public health coverage programs, and the appropriate federal agencies to establish and maintain a seamless process for consumers with regard to eligibility for public health coverage programs, including Medicaid, and the coverage and

subsidies available under the Act. The states will also need legislation to ensure that any private health insurance products offered outside the Exchange are prevented from unfairly competing with Exchange products.

The ACA allows age-based rate setting up to a 3 to 1 ratio. So for example, a healthy 60 year old could be charged $600 per month for the same policy that is available to a 27 year old for $200 per month. The federal law allows states to set a lower ratio. We urge Illinois to consider enacting a lower age rating.

Consumer assistance
Consumers, as individuals or members of small business groups, will want to know the cost of the health coverage alternatives (monthly premiums, deductibles, co-payments), the benefits that are offered, covered hospital and provider networks, and the subsidy that is available to help them pay for needed health insurance. It is important that consumers are able to easily compare options to a clear standard and receive help through hot lines and community-based "navigators." We've learned from Massachusetts that even what seemed to be a limited set of plan options appeared overwhelming to many enrollees. The public will need to be made aware of the Exchange and what it is offering and this will require a major communications and marketing campaign. Based on experience in states that have undertaken health reform, devoting resources to marketing the Exchange and its products, outreach and marketing must be viewed as a key operational element rather than an afterthought.

Cost containment
If the Exchange is to be sustainable over time, it must not only administer tax subsidies but also rein in health care costs overall. AARP believes that the Exchange should use its buying power to negotiate a better health coverage deal for all enrollees and also drive down costs and drive up value in the health care delivery system.

Lastly, AARP believes the state should also consider applying for the following grant opportunities. Some of the deadlines for application have already passed and we understand the state has applied for most of them. We are encouraged that the state has applied and/or will apply for these grants.

Health Center New Access Point Grants
Up to $250 million is available for new full-time service delivery site that provides comprehensive primary and preventive health care services for medically underserved populations in FY 2011. Public or nonprofit private entities, including tribal, faith-based and community-based organizations can apply for these competitive grants. Applications must be submitted by November 17, 2010

Consumer Assistance Program Grants
Up to $30 million is available to the states and territories to establish or strengthen health care insurance-related consumer assistance and ombudsman offices. Applications must be submitted by September 10, 2010

Planning Grants for State Health Insurance Exchanges
In this first round of Exchange-related grants, HHS is making up to $1 million per state available for the research and planning needed to determine how their Exchanges will be operated and governed. These are one year grants that will start on September 30, 2010. Future Exchange-related grant funds will be available through calendar 2014. Grant applications must be submitted by September 1, 2010.

Grants to Extend Money Follows the Person (MFP) Rebalancing Demonstration Projects
New funding ($2.25 billion) is available to the 20 states that do not have Money Follows the Person Rebalancing (MFP) Demonstration programs. Under MFP demonstration, states receive federal funding for a one-year period for each individual they transition from an institution to a home and community-based program. Funding is available through 2016 and applications must be submitted by January 2011.

Navigation and Long Term Services and Supports
HHS made $60 million in grants available to states and communities to help individuals and their caregivers better understand and navigate their health and long-term care options. Applications were due on July 30, 2010 and awards with be made in September 2010.

Criminal Background Check Program
CMS will make matching grants up to $3 million per states for expanded background checks for long-term care workers. States will be required to pay 25% of the cost. Applications were due June 25, 2010 and awards will be made by September 30.

Health Insurance Premium Rate Review Grants
HHS will provide grants of $1 million per state to review health insurance premium rate proposals. This is the first round of $250 million in funding to states over next five years. Grant applications were due by July 7, 2010 and awards will be made on August 9, 2010.

AARP is committed to the implementation of the Affordable Care Act and we look forward to working with the Illinois Health Reform Implementation Council in seeing the implementation go as smoothly as possible. Again, thank you for this opportunity to participate in the hearing with verbal and written comments.

Respectfully submitted:
Courtney Hedderman
Associate State Director
AARP Illinois
222 N LaSalle St., Suite 710
Chicago, IL 60601
312/458-3624
chedderman@aarp.org